36.07: continued

(3) Basic Federally - Mandated Disproportionate Share Adjustment.

(a) The Division determines a federally-mandated Medicaid disproportionate share adjustment for all eligible hospitals, using the data and methodology described below. The Division uses the following data sources in its determination of the federally-mandated Medicaid disproportionate share adjustment, unless the specified data source is unavailable. If the specified data source is unavailable, then the Division determines and uses the best alternative data source.

1. The Division uses free care charge data from the prior year filing of the Division's uncompensated care reporting form..

2.. The prior year RSC-403 report is used to determine Medicaid days, total days, Medicaid inpatient net revenues, total inpatient charges, and the state and/or local cash subsidy.

(b) The Division calculates a threshold Medicaid inpatient utilization rate to be used as a standard for determining the eligibility of acute care hospitals for the federally-mandated disproportionate share adjustment. The Division determines such threshold as follows:

1. First, calculate the statewide weighted average Medicaid inpatient utilization rate. This is determined by dividing the sum of Medicaid inpatient days for all acute care hospitals in the state by the sum of total inpatient days for all acute care hospitals in the state.

2. Second, calculate the statewide weighted standard deviation for Medicaid inpatient utilization statistics.

3. Third, add the statewide weighted standard deviation for Medicaid inpatient utilization to the statewide average Medicaid inpatient utilization rate. The sum of these two numbers is the threshold Medicaid inpatient utilization rate.

4. The Division then calculates each hospital's Medicaid inpatient utilization rate by dividing each hospital's Medicaid inpatient days by its total inpatient days. If this hospital-specific Medicaid inpatient utilization rate equals or exceeds the threshold Medicaid inpatient utilization rate calculated pursuant to 114.1 CMR 36.07(3)(b)3., then the hospital is eligible for the federally-mandated Medicaid disproportionate share adjustment under the Medicaid utilization method.

(c) The Division then calculates each hospital's low-income utilization rate as follows:

1. First, calculate the Medicaid and subsidy share of gross revenues according to the following formula:

$$\frac{\text{Medicaid gross revenues + state and local government cash subsidies}}{\text{Total revenues + state and local government cash subsidies}}$$

2. Second, calculate the free care percentage of total inpatient charges by dividing the inpatient share of free care charges less the portion of state and local government cash subsidies for inpatient services by total inpatient charges.

3. Third, compute the low-income utilization rate by adding the Medicaid and subsidy share of total revenues calculated pursuant to 114.1 CMR 36.07(3)(c)1. to the free care percentage of total inpatient charges calculated pursuant to 114.1 CMR 36.07(3)(c)2. If the low-income utilization rate exceeds 25%, the hospital is eligible for the federally-mandated disproportionate share adjustment under the low-income utilization rate method.

(d) Payment Methodology. The payment under the federally-mandated disproportionate share adjustment requirement is calculated as follows:

1. For each hospital deemed eligible for the federally-mandated Medicaid disproportionate share adjustment under the Medicaid utilization method established in 114.1 CMR 36.07(3), the Division divides the hospital's Medicaid inpatient utilization rate calculated pursuant to 114.1 CMR 36.07(3)(b)4. by the threshold Medicaid inpatient utilization rate calculated pursuant to 114.1 CMR 36.07(3)(b)3. The ratio resulting from such division is the federally-mandated Medicaid disproportionate share ratio.

2. For each hospital deemed eligible for the basic federally mandated Medicaid disproportionate share adjustment under the low-income utilization rate method, but not found to be eligible for the federally-mandated Medicaid disproportionate share adjustment under the Medicaid utilization method, the Division divides the hospital's low-income utilization rate by 25%. The ratio resulting from such division is the federally-mandated Medicaid disproportionate share ratio.

36.07: continued

3. The Division then determines, for the group of all eligible hospitals, the sum of federally-mandated Medicaid disproportionate share ratios calculated pursuant to 114.1 CMR 36.07(3)(d)1. and 114.1 CMR 36.07(3)(d)2.

4. The Division then calculates a minimum payment by dividing the amount of funds allocated pursuant to 114.1 CMR 36.07(3)(e). by the sum of the federally-mandated Medicaid disproportionate share ratios calculated pursuant to 114.1 CMR 36.07(3)(d)3.

5. The Division then multiplies the minimum payment by the federally-mandated Medicaid disproportionate share ratio established for each hospital pursuant to 114.1 CMR 36.07(3)(d)1. and 2. The product of such multiplication is the payment under the federally-mandated disproportionate share adjustment requirement. This payment ensures that each hospital's utilization rate exceeds one standard deviation above the mean, in accordance with 42 U.S.C. § 1396r-4.

(e) The total amount of funds allocated for payment to acute care hospitals under the federally-mandated Medicaid disproportionate share adjustment requirement is $200,000 per year. These amounts are paid by the Division of Medical Assistance, and distributed among the eligible hospitals as determined pursuant to 114.1 CMR 36.07(3)(d)5.

(4) Disproportionate Share Adjustment for Safety Net Providers. The Division determines a disproportionate share safety net adjustment factor for all eligible hospitals, using the data and methodology described in 114.1 CMR 36.07(4).

(a) Data Sources. The Division uses free care charge data from the prior year's filing of the Division's UC-9x report and total charges from the DHCFP-403. If the specified data source is unavailable, then the Division determines and uses the best alternative data source.

(b) Eligibility of Disproportionate Share Hospitals for the Safety Net Provider Adjustment. The disproportionate share adjustment for safety net providers is a payment for hospitals which meet the following criteria:

1. is a public hospital or a public service hospital as defined in 114.1 CMR 36.02;

2. has a volume of Medicaid and free care charges in FY93, or for any new hospital, in the base year as determined by the Division of Health Care Finance and Policy which is at least 15% of its total charges;

3. is an essential safety net provider in its service area, as demonstrated by delivery of services to populations with special needs including persons with AIDS, trauma victims, high-risk neonates, or indigent or uninsured patients;

4. has completed an agreement with or is the specified beneficiary of an agreement with the Division of Medical Assistance for intergovernmental transfer of funds, as defined in federal regulations governing state financial participation as a condition of federal reimbursement, to the Medicaid program for the disproportionate share adjustment for safety net providers;

5. is the subject of an appropriation requiring an intergovernmental funds transfer;

6. the public entity obligated to make an intergovernmental funds transfer does in fact meet its obligation in accordance with the agreement referenced at 114.1 CMR 36.07(4)(b)4..

(c) Payment to Hospitals under the Adjustment for Safety Net Providers. The Division calculates an adjustment for hospitals which are eligible for the safety net provider adjustment, pursuant to 114.1 CMR 36.07(4)(b). This adjustment shall be reasonably related to the costs, volume, or proportion of services provided to patients eligible for medical assistance under Title XIX, or to low-income patients, and equals the amount of funds specified in an agreement between the Division of Medical Assistance and relevant governmental unit. The disproportionate share adjustment for safety net providers is not in effect for any rate year in which Federal Financial Participation (FFP) under Title XIX is unavailable for this payment. The amount payable is also subject to the amount of FFP which continues to be available for this payment.

(d) If a public entity has not met its obligation to make an intergovernmental funds transfer, the Division of Medical Assistance shall have the right to recoup any safety net disproportionate share payment amount which is conditioned on the receipt by the Commonwealth of said intergovernmental funds transfer.

36.07: continued

(5) Uncompensated Care Disproportionate Share Adjustment. Hospitals eligible for this adjustment are those that report "free care costs," as defined by 114.6 CMR 11.00 and who are participating in the free care pool administered by the Division pursuant to M.G.L. c. 118G. The payment amounts for eligible hospitals are determined by the Division in accordance with its regulations at 114.6 CMR 11.00. These payments are made to eligible hospitals in accordance with ivision's regulations and the interagency service agreement (ISA) between the Division of Medical Assistance and the Division of Health Care Finance and Policy. Eligible hospitals receive these payments on a periodic basis during the term of their Medicaid contract with the Division.

(6) Public Health Substance Abuse Disproportionate Share Adjustment. Hospitals eligible for this adjustment are those acute facilities that provide hospital services to low income individuals who are uninsured or are covered only by a wholly state-financed program of medical assistance of the Department of Public Health (DPH), in accordance with regulations set forth at 105 CMR 160.000, as limited in DPH's ISA with the Division of Medical Assistance (DMA). The payment amounts for eligible hospitals participating in the Public Health Substance Abuse program are determined and paid by DPH in accordance with regulations at 114.3 CMR 46.00 and DPH's ISA with DMA.

(7) Disproportionate Share Adjustment for Non-profit Acute Care Teaching Hospitals affiliated with a Commonwealth-Owned University Medical School. The Division will determine for FY98 and succeeding years a disproportionate share adjustment for the acute care teaching hospitals that have an affiliation with university medical schools owned by the Commonwealth of Massachusetts.

(a) Eligibility. In order to be eligible for this adjustment, the following conditions must be met:

1. the hospital must enter into an agreement with the state-owned university medical school to purchase medical education, clinical support, and clinical activities from the medical school;
2. the hospital must have a common mission as established by state law, with the state owned university medical school, to train physicians, nurses, and allied health professionals according to high professional and ethical standards and to provide quality health care services;
3. the hospital must have completed an agreement with or is the specified beneficiary of an agreement with the Division of Medical Assistance concerning intergovernmental transfer of funds, as defined in federal regulations governing state financial participation as a condition of federal reimbursement, to the Medicaid program for this disproportionate share adjustment;
4. the hospital must be the subject of an appropriation requiring a public entity to make an intergovernmental funds transfer; and.
5. The public entity obligated to make an intergovernmental funds transfer does in fact meet its obligation in accordance with the agreement referenced in 114.1 CMR 36.07(7)(a)3.

(b) Payment amount. The Division calculates an adjustment for eligible hospitals. This adjustment will be reasonably related to the costs, volume, or proportion of services provided to patients eligible for medical assistance under Title XIX, or to low-income patients, and will equal the amount of funds specified in an agreement between the Division of Medical Assistance and the relevant governmental unit. This disproportionate share adjustment is subject to the availability of federal financial participation.

36.08: Medicaid Rates of Payment for Emergency Services at Hospitals that Do Not Contract with the Division of Medical Assistance

(1) Overview. 114.1 CMR 36.08 establishes rates of payment to acute care hospitals who have not signed a contract with the Division of Medical Assistance. Rates of payment for all emergency services and continuing emergency care provided in an acute hospital to medical assistance program recipients, including examination or treatment for an emergency medical condition or active labor in women or any other care rendered to the extent required by 42 USC 1395(dd), are as follows.

114.6 CMR 11.00: ADMINISTRATION OF THE UNCOMPENSATED CARE POOL

Section

11.01: General Provisions

(1) Scope, Purpose and Effective Date. 114.6 CMR 11.00 governs the procedures effective October 1, 1998 for administering the Uncompensated Care Pool, including payments to acute hospitals and community health centers and payments from acute hospitals and surcharge payers.

(2) Authority. 114.6 CMR 11.00 is adopted pursuant to M.G.L. c. 118G.

11.02: Definitions

Meaning of Terms: As used in 114.6 CMR 11.00, unless the context otherwise requires, terms have the following meanings. All defined terms in 114.6 CMR 11.00 are capitalized.

Allowable Free Care Costs. A Hospital's total allowable Free Care Charges multiplied by its Cost to Charge Ratio.

Ambulatory Surgical Center. Any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring Hospitalization and meets the Health Care Financing Administration requirements for participation in the Medicare program.

Ambulatory Surgical Center Services. Services described for purposes of the Medicare program pursuant to 42 USC §1395k(a)(2)(F)(I). These services include only facility services and do not include physician fees.

Charge. The uniform price for a specific service charged by a Hospital or Community Health Center.

Commissioner. The Commissioner of the Division of Health Care Finance and Policy or designee.

Community Health Center. A clinic which provides comprehensive ambulatory services and which:

(a) is licensed as a freestanding clinic by the Massachusetts Department of Public Health pursuant to M.G.L. c. 111, § 51;
(b) meets the qualifications for certification (or provisional certification) by the Division of Medical Assistance and enters into a provider agreement pursuant to 130 CMR 405.000;
(c) operates in conformance with the requirements of 42 U.S.C. § 254(c); and
(d) files cost reports as requested by the Division.

Compliance Liability Revenues. Amounts paid by Hospitals into the Uncompensated Care Trust Fund pursuant to St. 1991, c. 495, § 56.

Cost to Charge Ratio. A percentage used to reduce Uncompensated Care Charges to costs, calculated pursuant to 114.6 CMR 11.04(4).

Disproportionate Share Hospital. A Hospital which serves a disproportionate share of low income patients and which meets the criteria set forth in 114.1 CMR 36.06.

11.02: continued

Division. The Division of Health Care Finance and Policy established under M.G.L. c. 118G or its designated agent.

Emergency Bad Debt. The amount of uncollectible debt for emergency services which meets the criteria set forth in 114.6 CMR 10.00.

Fiscal Year. The time period of 12 months beginning on October 1 of any calendar year and ending on September 30 of the following calendar year.

Free Care. Unpaid Hospital or Community Health Center Charges for medically necessary services which are eligible for reimbursement from the Uncompensated Care Pool pursuant to the criteria set forth in 114.6 CMR 10.00.

Governmental Unit. The commonwealth, any department, agency board, or commission of the Commonwealth, and any political subdivision of the commonwealth.

Gross Patient Service Revenue. The total dollar amount of a Hospital's Charges for services rendered in a Fiscal Year.

Guarantor. A person or group of persons who assumes the responsibility of payment for all or part of a Hospital's or Community Health Center's Charge for services.

Hospital. An acute Hospital licensed under M.G.L. c. 111, § 51 and the teaching Hospital of the University of Massachusetts Medical School, which contains a majority of medical-surgical, pediatric, obstetric and maternity beds, as defined by the Department of Public Health.

Hospital Services. Services listed on a Hospital's license by the Department of Public Health.

Indirect Payment. A payment made by an entity licensed or approved under M.G.L. c.175, c.176A, c.176B, c.176G, or c.176I to a group of providers, including one or more Massachusetts acute care Hospitals or Ambulatory Surgical Centers, which then forward the payment to member Hospitals or Ambulatory Surgical Centers; or a payment made to an individual to reimburse him or her for a payment made to a Hospital or Ambulatory Surgical Center.

Individual Medical Visit. A face-to-face meeting between a recipient and a physician, physician assistant, nurse practitioner, or registered nurse within the Community Health Center setting, for purposes of examination, diagnosis, or treatment.

Individual Payer. A patient or Guarantor who pays his or her own Hospital or Ambulatory Surgical Center bill and is not eligible for reimbursement from an insurer or other source.

Institutional Payer. A Surcharge Payer that is an entity other than an Individual Payer.

Medicare Program. The medical insurance program established by Title XVIII of the Social Security Act.

Patient. An individual who is receiving or has received medically necessary services at a Hospital or Community Health Center.

Payment. A check, draft or other paper instrument, an electronic fund transfer, or any order, instruction, or authorization to a financial institution to debit one account and credit another.

Pool. The Uncompensated Care Pool established pursuant to M.G.L. c.118G, § 18.

Private Sector Charges. Gross Patient Service Revenues attributable to all patients less Gross Patient Service Revenue attributable to Titles XVIII and XIX, other publicly aided patients, Free Care and bad debt.

11.02: continued

Public Service Hospital. Any public Hospital or any acute Hospital operating pursuant to St. 1995, c. 147, which has a private sector payer mix that constitutes less than 25% of its Gross Patient Service Revenue (GPSR) and where Uncompensated Care comprises more than 20% of its GPSR.

Publicly Aided Patient. A person who receives Hospital or Community Health Center care and services for which a Governmental Unit is liable in whole or in part under a statutory program.

Registered Payer List. A list of Institutional Payers as defined in 114.6 CMR 11.05(3)(b).

Shortfall Amount. The difference between the sum of Allowable Free Care Costs for all Hospitals and the revenue available for distribution to Hospitals as set forth in 114.6 CMR 11.04(3)(d)

Sole Community Hospital. Any acute Hospital classified as a Sole Community Hospital by the U.S. Health Care Financing Administration's Medicare regulations, or any Hospital which demonstrates to the Division's satisfaction that it is located more than 25 miles from other acute Hospitals in the Commonwealth and that it provides services for at least 60% of its primary service area.

Specialty Hospital. An acute Hospital qualifying as exempt from the Medicare prospective payment system regulations or any acute Hospital which limits its admissions to patients under active diagnosis and treatment of eyes, ears, nose and throat or to children or patients under obstetrical care.

Surcharge Payer. An individual or entity that:
(a) makes payments for the purchase of health care Hospital Services and Ambulatory Surgical Center Services; and
(b) meets the criteria set forth 114.6 CMR 11.05(1)(a).

Surcharge Percentage. The percentage assessed on certain payments to Hospitals and Ambulatory Surgical Centers determined pursuant to 114.6 CMR 11.05(2).

Third Party Administrator. An entity that administers payments for health care services on behalf of a client plan in exchange for an administrative fee. A Third Party Administrator may provide client services for a self-insured plan or an insurance carrier's plan. Third Party Administrators will be deemed to use a client plan's funds to pay for health care services whether the Third Party Administrator pays providers with funds from a client plan, with funds advanced by the Third Party Administrator subject to reimbursement by the client plan, or with funds deposited with the Third Party Administrator by a client plan.

Uncompensated Care. The sum of reported net Free Care and net Emergency Bad Debt.

11.03: Reporting Requirements

(1) General. Each Hospital, Community Health Center, Surcharge Payer and Ambulatory Surgical Center shall file or make available information which is required or which the Division deems reasonably necessary for implementation of 114.6 CMR 11.00.

(a) Due Date. For any filing requirement without a specified time for filing, the submission is due 15 days from the date of the request of the Division. The Division may, for cause, extend the filing date. Any request for an extension must be made in writing and submitted to the Division in advance of the filing date.

(b) Patient Level Data. Hospitals and Community Health Centers must make Uncompensated Care Pool patient level data available to the Division upon request. These patient level data include but are not limited to cost data, patient diagnoses and types of uncompensated services provided, patient demographics, write-off amounts, unique patient identifiers, and other such data that enable the Division to conduct analyses, verify eligibility, and calculate settlements on a case-by-case basis.

11.03: continued

(c) Audit. The Division may audit data submitted under 114.6 CMR 11.03 to ensure accuracy. The Division may adjust reported Free Care to reflect audit findings.

(2) Hospitals.

(a) UC Form. Each Hospital must submit a DHCFP UC-Form monthly within 45 days after the end of the reporting period.

(b) Monthly Report. Each Hospital must report monthly to the Division the total amount of payments for services received from each Institutional Payer which does not appear on the Registered Payer List. Hospitals must also report monthly the total amount of payments received from Individual Payers whose payments are subject to the surcharge and the surcharge amount paid. Hospitals must report these data in an electronic format specified by the Division. Hospitals must submit these data by the first business day of the second month following the month during which the payment was received. For example, data regarding payments received in January shall be due on March 1.

(c) Quarterly Report. Each Hospital must report total payments made by Institutional Surcharge Payers for reporting periods specified by the Division in a format specified by the Division.

(d) Annual Report. Each Hospital must report annually to the Division the total amount of payments received from each Surcharge Payer. The Division may waive reporting on payers whose payments to the Hospital do not meet a threshold amount established by the Division. Hospitals must report these data in an electronic format specified by the Division.

(e) Penalties. The Division may deny reimbursement for Free Care to any Hospital which fails to comply with the reporting requirements of 114.6 CMR 11.00 until such Hospital complies with the requirements. The Division will notify such Hospital of its intention to withhold reimbursement.

(3) Community Health Centers.

(a) Free Care Payment Voucher. Each Community Health Center must submit a monthly payment voucher detailing the center's Individual Medical Visits that qualify for Free Care within 45 days after the last day of the designated reporting period.

(b) Each Community Health Center must, upon request, provide the Division with patient account records and related reports as set forth in 114.6 CMR 11.03(1)(b).

(c) Penalties. The Division may deny reimbursement for Free Care to any Community Health Center which fails to comply with the reporting requirements of 114.6 CMR 11.00 until such Community Health Center complies with the requirements. The Division will notify Community Health Centers of its intention to withhold reimbursement.

(4) Surcharge Payers.

(a) Institutional Payers.

1. Annual Report. Except for non-United States National insurers with less than ten payments per year in the prior three years to Massachusetts Hospitals and/or Ambulatory Surgical Centers, each Institutional Payer must submit an annual report to the Division. This report must contain data regarding its payments to Hospitals and Ambulatory Surgical Centers in the previous year, payments exempt from surcharge, adjustments made for over- or under-payments of the surcharge, and any other information necessary to calculate the surcharge amount owed. These data must be submitted in an electronic format specified by the Division.

2. Monthly Report. If the Division determines that there is a material variance between prior surcharge payments or projected surcharge payments, the Division may require a Surcharge Payer to submit monthly reports of payments to Hospitals and Ambulatory Surgical Centers.

(b) Third Party Administrators.

1. Monthly Report. A Surcharge Payer that is a Third Party Administrator and that makes payments to Hospitals and Ambulatory Surgical Centers on behalf of one or more insurance carriers must file a monthly report with the Division. The report shall include the surcharge amounts that the Third Party Administrator paid on behalf of each insurance carrier, and on behalf of all its self-insured clients combined. The report shall be in an electronic format specified by the Division.

11.03: continued

2. Third Party Administrators must submit these data by the first business day of the second month following the month during which the payment was received. For example, data regarding payments made in January is due to the Division on March 1.

(c) Penalties. Any Surcharge Payer that fails to file data, statistics, schedules, or other information pursuant to 114.6 CMR 11.03 or which falsifies same, shall be subject to a civil penalty of not more than $5000 for each day on which such violation occurs or continues, which penalty may be assessed in an action brought on behalf of the Commonwealth in any court of competent jurisdiction. The Attorney General shall bring any appropriate action, including injunction relief, as may be necessary for the enforcement of the provisions of 114.6 CMR 11.00.

(5) Ambulatory Surgical Centers.

(a) Monthly Report. Each Ambulatory Surgical Center must report monthly to the Division the total amount of payments for services received from Institutional Surcharge Payers which do not appear on the Registered Payer List. Ambulatory Surgical Centers must also report monthly the total amount of payments received from Individual Payers whose payments are subject to the surcharge and the surcharge amount paid. The report shall be in an electronic format specified by the Division. Ambulatory Surgical Centers must submit these data by the first business day of the second month following the month during which the payment was received. For example, data regarding payments received in January is due to the Division on March 1.

(b) Quarterly Report. Each Ambulatory Surgical Center must report total payments made by Institutional Surcharge Payers during each quarter of the Fiscal Year in a format specified by the Division.

(c) Annual Report. Each Ambulatory Surgical Center must report annually to the Division the total amount of payments received from Surcharge Payers. The Division may waive reporting on payers whose payments to the Ambulatory Surgical Center do not meet a threshold amount. Ambulatory Surgical Centers must report these data in an electronic format specified by the Division.

(d) Penalties. An Ambulatory Surgical Center that knowingly fails to file with the Division any data required by 114.6 CMR 11.03 or knowingly falsifies the same shall be subject to a $500.00 fine.

11.04: Payments From and To Hospitals

(1) Revenue Available for Payments to Hospitals for Free Care.

(a) Available revenue for each Fiscal Year consists of:

1. revenues produced by Hospital assessments under 114.6 CMR 11.04
2. revenues produced by the Uncompensated Care Pool Surcharge under 114.6 CMR 11.05,
3. supplemental funding consisting of designated Compliance Liability Revenues; and
4. state appropriations of federal financial participation funds and any other available appropriations and
5. for FY 98, supplemental funding shall consist of $4 million transferred from Compliance Liability Revenues.

(b) Available revenue is reduced by:

1. payments to Community Health Centers under 114.6 CMR 11.06;
2. amounts withheld as reserves for contingencies;
3. expenses for administration of the Pool authorized by M.G.L. c. 118G;
4. demonstration projects authorized under M.G.L. c. 118G, § 18(d)
5. expenses for managed care contracts or interagency service agreements to provide services to indivduals eligible for free care as authorized by M.G.L. c. 118G, § 18(j).

(c) Supplemental funding is the primary source of funding for Free Care to Community Health Centers. If this funding source is insufficient, then revenue provided through other sources will be made available. Any supplemental funding remaining after payments to Community Health Centers will be made available for other Pool purposes.

11.04: continued

(d) For the purpose of demonstration projects, the Division may contract with health care delivery or management organizations or enter interagency service agreements with the Division of Medical Assistance or the Department of Public Health for contracts with managed health care providers to deliver services to individuals eligible for Free Care. The expenditures for such contracts shall not exceed 5,000,000 dollars in in FY 1998 through FY 2002.

1. For Fiscal Years 1998 through 2002, payments for demonstration projects will include the EcuCare Project in North Adams and the Hampshire Health Access Project in Hampton to link uninsured and underinsured individuals and families with health care providers willing to treat such persons at reduced or no costs, in amounts determined by the general court

2. For Fiscal Years 1998 to 2002, inclusive, the Division shall allocate $2,000,000 annually for a Massachusetts Fisherman's Partnership, Inc. Demonstration project.

(e) For FY 2000, supplemental funding shall consist of $15 million transferred from Compliance Liability revenue.

(2) Gross Liability to the Pool. A Hospital's gross liability to the Uncompensated Care pool is the product of (a) the ratio of its Private Sector Charges to all Hospitals' Private Sector Charges and (b) total Hospital liability to the Uncompensated Care pool as determined by the General Court for each Fiscal Year.

(3) Gross Liability to Hospitals. The Uncompensated Care Pool's gross liability to a Hospital is determined by the following calculation:

	Total Free Care Charges	(a)
X	Cost to Charge Ratio	(b)
=	Allowable Free Care Costs	(c)
-	Shortfall Allocation Amount	(d)
=	Pool Liability to Hospitals	(e)

(a) Hospital Free Care Charges are based on the Uncompensated Care Charges filed with the Division in accordance with 114.6 CMR 11.03.

(b) The Cost to Charge Ratio is calculated in accordance with 114.6 CMR 11.04(4).

(c) Allowable Free Care Costs are the product of total Free Care Charges and the Cost to Charge Ratio.

(d) The Shortfall Amount to be allocated is calculated in the following manner:

1. determine the ratio of a Hospital's total patient care costs to the sum of all Hospitals patient care costs;

2. multiply the ratio in 114.6 CMR 11.04(3)(a) by the Shortfall Amount;

3. If the calculated amount in 114.6 CMR 11.04(3)(a)2. is greater than a Hospital's Allowable Free Care Costs, then the shortfall allocation will be limited to a Hospital's Allowable Free Care Costs.

(e) The Pool's gross liability to each Hospital is equal to the Hospital's Allowable Free Care Costs less the shortfall allocation amount.

(4) Calculation of the Cost to Charge Ratio. The Division shall calculate for each Hospital a Cost to Charge Ratio used to determine the Pool's liability to the Hospital. The Cost to Charge Ratio is the sum of each Hospital's inpatient reasonable costs and actual outpatient costs, divided by the Hospital's Gross Patient Service Revenues.

(a) Data Sources. The Division will obtain cost and charge information, including capital cost, malpractice data and organ acquisition costs, from the DHCFP-403 Report. The Division will review the DHCFP-403 Cost Report to ensure that the costs and Charges reported on the DHCFP-403 Report reconcile with those reported on audited financial statements, and are true, accurate, and complete. For purposes of calculating case-mix indices, the Division will use the merged billing and case-mix information filed pursuant to 114.1 CMR 17.00.

11.04: continued

(b) Timing.

1. The Division will calculate a preliminary Cost to Charge Ratio before the beginning of each Fiscal Year, utilizing date from two years prior to the rate year.

2. The Division will calculate an interim Cost to Charge Ratio midway through the Fiscal Year when year end financial data from the prior Fiscal Year becomes available.

3. The Division will calculate a final Cost to Charge Ratio after the end of the Fiscal Year when final audited financial data for the rate year becomes available.

(c) Reasonable Inpatient Costs. The Division will determine reasonable inpatient costs by summing the Hospital's reasonable comparable costs, reasonable capital cost, direct medical education cost, malpractice cost, organ acquisition cost, Hospital-based physician salaries, and adjustments for inpatient Free Care provided by physicians and undocumentable Free Care, if applicable. The calculation is as follows:

Reasonable Inpatient Costs =

Reasonable comparable costs
+ Reasonable capital expense
+ Direct medical education expense
+ Malpractice expense
+ Organ acquisition expense
+ Hospital-based physician salaries
+ Adjustment for inpatient Free Care provided by physicians, if applicable
+ Adjustment for undocumentable Free Care, if applicable

The calculation of reasonable comparable costs is set forth in 114.6 CMR 11.04(4)(c)1. The calculation of reasonable capital expense is set forth in 114.6 CMR 11.04(4)(c)2. The adjustment for inpatient Free Care provided by physicians is set forth in 114.6 CMR 11.04(4)(c)3. The adjustment for undocumentable Free Care is set forth in 114.6 CMR 11.04(4)(c)4.

1. Reasonable Comparable Costs. The Division will use an efficiency standard to determine reasonable comparable costs. Reasonable comparable costs equal the efficiency standard for Hospitals whose inpatient costs exceed the efficiency standard described below. Reasonable costs will equal actual costs for Hospitals whose costs do not exceed the efficiency standard. Specialty Hospitals, Sole Community Hospitals, and Public Service Hospitals will not be subject to the efficiency standard. The Division will calculate the efficiency standard as follows:

a. First, the Division will determine comparable costs by subtracting non-comparable costs from total inpatient costs. Non-comparable costs are: capital, direct medical education, malpractice, organ acquisition costs, and Hospital-based physician salaries. The methodology and specific data sources used to calculate these non-comparable costs will be distributed to Hospitals.

Comparable costs = Total inpatient costs
- Capital cost
- Direct Medical education cost
- Malpractice cost
- Organ acquisition cost
- Hospital-based physician salaries

b. Second, the Division will determine comparable costs per discharge by dividing the comparable costs by total discharges.

Comparable cost per discharge = $\frac{\text{total comparable costs}}{\text{total discharges}}$

11.04: continued

c. Third, the Division will adjust the comparable cost per discharge for case mix and wage area. The case-mix index will be calculated using the AP-DRG Grouper (the New York State Grouper) and New York weights. The Grouper version used will be appropriate for the ICD-9-CM diagnosis and procedure codes of the year from which the financial data is taken. The wage area indices will be those calculated by the Health Care Financing Administration (HCFA), and will be applied only to the labor portion of costs, also as determined by the Health Care Financing Administration.

Standardized cost per discharge = Comparable cost per discharge
/ case mix index
/ wage area index

d. Fourth, the Division will calculate the mean standardized cost per discharge for all Hospitals weighted by the number of discharges in each Hospital. Specialty Hospitals, Sole Community Hospitals, and Public Service Hospitals will be excluded from this calculation. The statewide mean standardized cost per discharge is the efficiency standard.

e. i. For Hospitals whose own standardized cost per discharge is greater than the efficiency standard, the Division will calculate reasonable comparable costs as follows. First, the Division will adjust the efficiency standard for wage area and case-mix. The wage area index will be applied only to the labor portion of costs, as determined by the Health Care Financing Administration. Second, the Division will multiply these reasonable adjusted costs per discharge by total discharges to determine reasonable comparable costs.

Reasonable adjusted cost per discharge = Efficiency standard
x wage area index
x case mix index

Reasonable comparable costs = Reasonable adj. cost per discharge
x total discharges

ii. For Hospitals whose standardized cost per discharge is less than the efficiency standard, and for Specialty Hospitals, Sole Community Hospitals and Public Service Hospitals, the Division will determine that reasonable comparable costs are equal to actual comparable costs as calculated in 114.6 CMR 11.04(4)(c)1.a..

2. Reasonable inpatient capital costs. Inpatient capital costs will be held to reasonable limit. This capital cost limit will be phased in over five years. In Pool FY97 and forward, the Division will include in reasonable costs only capital costs equal to or below of the reasonable capital cost limit. The Division will determine reasonable inpatient capital costs as follows:

a. The Division will calculate inpatient capital costs per discharge by dividing total capital costs allocated to inpatient by total discharges.

b. The Division will adjust inpatient capital costs per discharge for case mix. The case-mix index will be calculated using the AP-DRG Grouper (the New York State Grouper) and New York weights. The Grouper version used will be appropriate for the ICD-9-CM diagnosis and procedure codes of the year from which the financial data is taken.

c. The Division will determine the case-mix adjusted capital costs limit (CMCCL) by first sorting acute care Hospital's adjusted costs in ascending order, and then producing a cumulative frequency of discharges. The CMCCL is established at the case-mix adjusted capital cost per discharge corresponding to the median discharge for the FY93 cost to charge calculation, and multiplied by an inflation factor. The year to year inflation factors are: 3.01% for FY94; 2.80% for FY 95; 1.8% for FY96; 1.0% for FY97; no adjustment for FY 98; and 0.8% for FY99. This efficiency

11.04: continued

standard will be phased-in over a five year period in order to enable Hospitals to make necessary adjustments. As a result, 20% of excess costs will be disallowed in FY93, 40% of costs will be disallowed in FY94, and 60% of costs will be disallowed in FY95, and 80% of excess costs will be disallowed in FY96, and 100% of excess costs will be disallowed in FY97 and forward.

Sole Community Hospitals, Specialty Hospitals, and Public Service Hospitals will be excluded from this calculation.

d. Each Hospital's case-mix adjusted capital cost per discharge determined in 114.6 CMR 11.04(4)(c)2.b. is then compared to the case-mix adjusted capital costs limit (CMCCL) calculated in 114.6 CMR 11.04(4)(c)2.c..

e. For Hospitals whose own case-mix adjusted capital cost per discharge is less than or equal to the CMCCL, reasonable capital cost per discharge is equal to the Hospital's actual adjusted capital cost per discharge multiplied by the Hospital's case-mix index.

For Hospitals whose own case-mix adjusted capital cost per discharge is greater than the CMCCL, the FY93 reasonable capital cost per discharge is equal to the product of a) the sum of the CMCCL and 80% of the excess above the CMCCL, and b) the Hospital's case-mix index. For FY94, the reasonable capital cost per discharge is equal to the product of a) the sum of the CMCCL and 60% of the excess above the CMCCL, and b) the Hospital's case-mix index. For FY95, the reasonable capital cost per discharge is equal to the product of a) the sum of the CMCCL and 40% of the excess above the CMCCL, and b) the Hospital's case-mix index. For FY96, the reasonable capital cost per discharge is equal to the product of a) the sum of the CMCCL and 20% of the excess above the CMCCL, and b) the Hospital's case-mix index. For FY97 and forward, the reasonable capital cost per discharge is equal to the product of a) the CMCCL, and b) the Hospital's case-mix index.

f. The Division will determine reasonable inpatient capital costs by multiplying the reasonable capital cost per discharge calculated in 114.6 CMR 11.04(4)(c)2.e. by total discharges.

For Sole Community Hospitals, Specialty Hospitals, and Public Service Hospitals, reasonable inpatient capital costs equal actual inpatient capital costs.

3. Allowance for Free Care Provided by Physicians. The Division will increase the reasonable costs of qualifying Disproportionate Share Hospitals to include an allowance for Free Care provided by physicians.

a. The Division will allocate $2,500,000 for this allowance.

b. The Division will calculate the ratio of allowable Free Care Charges to total Charges for all Disproportionate Share Hospitals. For periods prior to July 1, 1996, the Division will use allowable Free Care charge data from the Department of Medical Security records. For periods after July 1, 1996, the Division will use allowable Free Care charge data from the DHCFP UC form. The Division will obtain total charge data from the DHCFP-403 report.

c. The Division will then rank the eligible Hospitals from highest to lowest by the ratios of allowable Free Care to total Charges. The Division will determine the 75th percentile of the ranked Hospitals.

d. For FY95 and thereafter, Hospitals which meet or exceed the 75th percentile will qualify to receive the allowance for Free Care provided by physicians.

e. The Division will multiply each qualifying Hospital's allowable Free Care Charges by a Cost to Charge Ratio to determine Allowable Free Care Costs.

i. Beginning with the FY94 Final Cost to Charge Ratio, the Allowable Free Care Costs will be based on data from two years prior. The Division will multiply each qualifying Hospital's allowable Free Care Charges prior by the Hospital's most recently calculated prior year Cost to Charge Ratio.

ii. Beginning with the FY95 Interim Cost to Charge Ratio, the Allowable Free Care Costs will be based on data from three years prior. The Division will multiply each qualifying Hospital's Free Care Charges by the Hospital's most recently calculated two year prior Cost to Charge Ratio.